INSURE MONTANA

INSURING MONTANANS ONE SMALL BUSINESS AT A TIME

BANK ACCOUNT CHANGE FORM

All changes to bank information will be effective on the next scheduled payment.

Employer Name:_____

Check one:

☐ I am an employer changing banking information for my premium incentive payment.

☐ I am an employee changing banking information for my premium assistance payment.

Bank Account Information

Information collected will be used for Electronic Funds Transfer (EFT) to deposit your monthly premium incentive or premium assistance subsidy payment. **Include a voided check with this form.** If a voided check is not available, attach a letter from your financial institution indicating the bank transit routing and account numbers. The document must be on bank letterhead and signed by a bank official. **Do not send deposit slips.**

Name on Account: _____

Transit Routing Number (9 digits): _____

Bank Account Number (include zeros, do not include check number): _____

Type of Account (select only **one**): __ Checking ___ Savings Date Bank Account Opened: _____/_____/_____

Financial Institution Name: _____

Bank Address: _____

City: _____ State: _____ Zip: _____

Bank Phone Number: _____ Ext: _____

Attach voided check in this space.

I certify, under penalty of law, that all my answers are correct and complete to the best of my knowledge. I understand the penalty for withholding or giving false information which may include a possible criminal offense (MCA 33-22-2009). I agree to provide documents to verify information on this application if requested. I understand that State staff may obtain documents and/or information to verify statements on this application. I also understand that I must report if my coverage ends within 30 days of the change. Any premium assistance payment I receive and am not entitled to will be required to be repaid to the Insure Montana program.

Signature: _____ Date: _____